

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-022038

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

042

Primary Registration District No.

1000

Registrar's No.

684

FILED JUN 18 1962

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Buchanan</u>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>                          |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>St. Joseph</u>  |   | c. CITY OR TOWN <u>St. Joseph</u>  |   |
| Length of stay in 1b<br><u>life</u>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Methodist Hospital</u>  |   | d. STREET ADDRESS (If outside, give location)<br><u>2305 Mitchell Ave.</u>   |   |
| Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Molly</u> Middle <u>Marie</u> Last <u>Lanning</u>  |   | 4. DATE OF DEATH<br>Month <u>June</u> Day <u>10</u> Year <u>1962</u>   |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>          | 8. DATE OF BIRTH<br><u>May 26, 1897</u> |
| 9. AGE (last birthday)<br><u>71</u>   |   | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own home</u>   |   |
| 11. BIRTHPLACE (City and state or country)<br><u>St. Joseph, Mo.</u>  |   | 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>  |   |
| 13a. FATHER'S NAME<br><u>Charles Abler</u>  |   | 13b. MOTHER'S MAIDEN NAME<br><u>(unknown)</u>  |   |
| 14. NAME OF HUSBAND OR WIFE<br><u>William O. Lanning</u>  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service)<br><u>No</u>             |   |
| 16. INFORMANT<br><u>William O. Lanning</u>  |   | Address<br><u>2305 Mitchell Ave.</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u><br>DUE TO (b) <u>Coronary Insufficiency</u><br>DUE TO (c) <u>  </u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>Months</u><br><u>Months</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u><br>Month, Day, Year <u>  </u>   | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>    |  |   |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 20f. CITY, TOWN, OR LOCATION<br>COUNTY <u>  </u> STATE <u>  </u>   |   |
| 21. I attended the deceased from <u>May 1:50 a</u> to <u>June 10 62</u> and last saw her alive on <u>6-9-62</u><br>Death occurred at <u>  </u> m on the date stated above, and to the best of my knowledge, from the causes stated.   |   |  |   |
| 22a. SIGNATURE<br>(Degree or title)<br><u>M.E. Grimes M.D.</u>  |   | 22b. ADDRESS<br><u>St Joseph MO</u>  |   |
| 22c. DATE SIGNED<br><u>6-12-62</u>  |   | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |   |
| 23b. DATE<br><u>June 13, 1962</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Forest Hill Cemetery</u>  |   |
| 23d. LOCATION (City, town, or county)<br><u>Kansas City, Missouri</u>   |   | 23e. LOCATION (City, town, or county)<br><u>  </u> (State) <u>  </u>   |   |
| 24. FUNERAL DIRECTOR<br><u>Clark Funeral Home</u>   |   | 25. DATE RECD. BY LOCAL REG.<br><u>June 14, 1962</u>   |   |
| 26. REGISTRAR'S SIGNATURE<br><u>Mrs. Clark Goodell</u>  |   | 27. REGISTRAR'S SIGNATURE<br><u>  </u>   |   |

USE BLACK INK  
OR  
TYPEWRITER RIBBONAMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

M.E. Grimes, M.D.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Paul F. Clark

Licensed Embalmer No. 5024

P. O. Address St. Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.